

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004172

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

354

STATE FILE NUMBER

FILED JAN 17 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN Ladue	
c. FULL NAME OF (If NOT in hospital, give location) St. Lukes Hospital		d. STREET ADDRESS (If outside, give location) 24 Deerfield Rd.	
3. NAME OF DECEASED (Type or print) First JANE Middle FORDER Last STRIBLING		4. DATE OF DEATH Month Jan. Day 11 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 50
11a. FATHER'S NAME Wm. Carver Forder		11b. BIRTHPLACE (City and state or country) St. Louis County Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. MOTHER'S MAIDEN NAME Annie Laurie Forder		14. NAME OF HUSBAND OR WIFE G. Carroll Stribling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) No		17. INFORMANT G. Carroll Stribling 24 Deerfield Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 170 X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. Louis	
21. I attended the deceased from 8/24/61 to 1/11/63 and last saw her alive on 1/10/63. Death occurred at 6:06 AM on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) John B. Shapleigh M.D.	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/14/1963	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery St. Louis Mo
24. FUNERAL DIRECTOR Lupton Chapel 7233 Delmar Blvd.		25. DATE RECD. BY LOCAL REG. JAN 12 1963	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS.300
Rev. 4/59

1

24024-3

3

4 1

5 1

6

7 0

8 1

9

10

11

12 81-0

13

81

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Arnold W. Schoene

Licensed Embalmer No.

3864

P. O. Address

St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.